IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER

Complaint Intake #: 47169-C
47230-C

April 7, 2014

Ms. Sue Hyde, Executive Director
Keelson Harbour Assisted Living
2810 Aurora Avenue
Spirit Lake, IA 51360

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - KEELSON HARBOUR ASSISTED LIVING
II. Reduction of Civil Penalty
III. Informal Conference
IV. Conclusion

Dear Ms. Hyde:

I. Final Complaint/Incident Investigation Report – Keelson Harbour Assisted Living, Spirit Lake, IA

Enclosed is the **Final Complaint/Incident Investigation Report ("Report")** issued by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following an investigation by DIA on **March 10 - 13, 17 and 24, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluations, Service Plans, Medications, Nurse Review, Staffing, Tenant Rights, Program Reporting to Department, Criteria for Admission and Retention, Tenant Documents, Food Service, Dementia Specific Education, Life Safety, Structural and Policies and Procedures.

Keelson Harbour Assisted Living ("Program") is being assessed a **$3,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a)(b) and 481 IAC 67.17(1)(a)(b).

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to your program coordinator within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

Pursuant to Iowa Code section 231C.14(1)(a)(b) and 481 IAC rule 67.17(1)(a)(b), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000 and the continued failure or refusal to comply within a prescribed time frame with regulatory requirements that have a direct relationship to the health, safety, or security of tenants may result in a civil penalty of up to $5,000.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.17(3) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The determination of a **$3,000 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm by failing to secure chemicals in a dementia specific unit and for repeated Regulatory Insufficiencies in the areas of: Evaluations, Service Plans, Medications, Nurse Review and Staffing.

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program previously received Regulatory Insufficiencies in the areas of Evaluations, Service Plans, Medications, Nurse Review and Staffing.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481−67.17(5). If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Jim Berkley** and remit the civil penalty assessed by check or money order to the **State of Iowa** in the amount of **one thousand nine hundred and fifty dollars ($1950)** within 30 days after the notice or service of this demand letter.

III. Informal Conference

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

IV. Conclusion

The Program is being assessed a **$3,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a)(b) and 481 IAC 67.17(1)(a)(b).

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so as provided in IAC rule 481-67.14.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Jim Berkley, at 515/281-4116 or **James.Berkley@dia.iowa.gov**.

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Sue Hyde, Executive Director
Keelson Harbour Assisted Living
2810 Aurora Avenue
Spirit Lake, IA 51360

Complaint/Incident Intake #: 47169-C
47230-C

Date of Complaint/Incident Investigation:

March 10, 11, 12, 13, 17 and 24, 2014

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS
Wendy Kuhse, RN BS

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 69 that serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to and approved by the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	43
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	45
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	22
Total Population of Program at time of on-site	23
TOTAL census of Assisted Living Program	68

Program History – The program received regulatory insufficiencies in the areas of Evaluations, Service Plans, Medications, Nurse Review, Staffing, Tenant Rights, Program Reporting to the Department, Criteria to Admission and Retention, Tenant Documents, Food Service, Dementia Education, Life Safety, Structural and Policy and Procedure during this certification period

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Tenant Rights

Complaint/Incident Allegation #47230-C: It was alleged tenants feared retaliation, intimidation and was frightened they would be forced to leave the Program.

- Monitoring Observation: An announcement was made at the noon meal inviting all tenants to a community meeting later that afternoon. A community meeting was held with 10 tenants and 1 family member and private interviews were held with 2 tenants and 1 family member. The tenants stated they liked living at the Program and wanted to continue to live there but had numerous concerns. There was lots of staff turnover and staff was not given enough training. Staff didn't understand they were caring for older people. The tenants stated they felt comfortable bringing concerns to management but they didn't get any answers. They reported being told they were trouble makers, they complained too much and were given the cold shoulder. They were told not to talk to others.

Tenant's stated it was stressful living at the Program. When asked if they feared retaliation they replied "Yes." One tenant asked if by attending the community meeting would they now be told they had to move?

The Former Activity Director (AD) was interviewed and stated tenants would share their concerns with her. She was instructed by the ED and the Nurse to not talk to "the trouble makers."

Per tenant and family interviews, comments and a staff interview, numerous tenants feared reprisal, restraint, interference, coercion or discrimination.

- Regulatory Insufficiency: To present grievances and recommend changes in program policies and services, personally or through other persons or in combination with others, to the program's staff or person in charge without fear of reprisal, restraint, interference, coercion, or discrimination. (IAC r. 481-67.3(8))

Complaint/Incident Allegation #47230-C: It was alleged staff routinely knocked on tenant doors but did not wait for a tenant response before entering the tenant apartment.

- Monitoring Observation: An announcement was made at the noon meal inviting all tenants to a community meeting later that afternoon. A community meeting was held with 10 tenants and 1 family member and private interviews were held with 2 tenants and 1 family member. The tenants reported staff would knock on the door and walk right in or staff just came in without knocking. The tenants considered this an invasion of their privacy.

  Staff #6, #8 and #9 stated they knocked on the door and waited for a response before entering. Staff #7 stated she knocked, waited for a response and if no response she opened the door and entered. Staff #4 stated it depended on the tenant as to whether she knocked and waited to enter or not. The Memory Care (MC) Nurse stated it depended on the tenant as to whether staff knocked or entered without knocking. The Executive Director (ED) and the Nurse stated staff knocked on the door and waited before entering the apartment.

  Per tenant and family interviews, Staff #4 and the Memory Care Nurse interviews, staff did not routinely knock and wait for a response before entering tenant apartments. Tenants were not treated with consideration and respect for privacy and dignity.

Complaint/Incident Allegation #47230-C: It was alleged the supply of insulin needles frequently ran out and staff was instructed to take insulin needles from a tenant who was not on the premises.

- Monitoring Observation: Tenant #11, an 88 year old, was admitted on 8-4-12 and diagnoses include: Diabetes. According to a Service Plan dated 8-19-13, Tenant #11 was independent in medication administration and self-administered medication safely. Tenant #11 took diabetic medications.

  The ED stated there was one incident when the Nurse ordered insulin needles and the needles did not come in so she called Tenant #11 who was out of state and asked if needles could be borrowed from Tenant #11's supply and Tenant #11 stated they could. The needles were replaced. The Nurse stated one time insulin supplies were taken from one tenant to be used for another tenant. She stated Tenant #11 was asked if the Program could borrow insulin needles and Tenant #11 said it was okay.

  Tenant #11 was interviewed and asked if the Program had ever run out of insulin needles and asked if they could borrow Tenant #11's needles. Tenant #11 stated "No they had not." Tenant #11 was asked if the ED or the Nurse had asked if they could borrow insulin needles and Tenant #11 stated "No."

  Per Tenant #11's interview, Tenant #11 had never been asked if the Program could borrow insulin needles. The ED and the Nurse admitted taking insulin needles from Tenant #11 when the Program ran out of insulin needles.

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Tenant #6, an 86 year old, was admitted on 12-09-11 and diagnoses include: Alzheimer's Disease. Tenant #6 was staged at a seven on the Global Deterioration Scale (GDS) which indicated very severe cognitive decline. Tenant #6 resided in the dementia unit. Tenant #6 received Hospice services.

  Monitor observation on 3-12-14 at 5:02 p.m. revealed Staff #2 and #3 entered Tenant #6's apartment and left the door to the apartment wide open. Staff approached Tenant #6 and called Tenant #6 by name. Tenant #6 did not respond or open Tenant #6's eyes. Staff #3 gently touched Tenant #6's face, while calling Tenant #6's name and informed Tenant #6 what they were going to do. Staff donned gloves and lowered the foot rests of the recliner chair and attempted a pivot transfer to the wheelchair. Tenant #6 could not/did not stand, and staff demonstrated difficulty in the transfer with Tenant #6's knees almost touching the floor. Staff #2 and #3 attempted a second transfer, that time successful in assisting Tenant #6 to the wheelchair. Staff then escorted Tenant #6 to the bathroom and then transferred Tenant #6 to the toilet. After sitting briefly and without results staff placed a clean perineal-liner and replaced Tenant #6's outer clothing.

  During this entire time the door to Tenant #6's apartment was wide open. Tenant #6's apartment was noted to be adjacent to the great room of the dementia unit where at least 15 other tenants were seated or wandering in the area awaiting the evening meal.

  While Tenant #6 could not advocate on Tenant #6's behalf regarding privacy when using the restroom, it is usual and customary for all individuals to close doors to ensure privacy and respect when using the restroom.

- Regulatory Insufficiency: All tenants have the following rights: To be treated with consideration, respect, and full recognition of personal dignity and autonomy. (IAC r. 481-67.3(1))

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Monitor observation on 3-12-14 at 5:02 p.m. revealed Tenant #6 positioned in the recliner and Staff #2 and #3 approached Tenant #6 and called Tenant #6's name. Tenant #6 did not respond or open Tenant #6's eyes. Staff #3 gently touched Tenant #6 face, while calling Tenant #6's name and informed Tenant #6 what they were going to do.

  Staff #2 and #3 attempted two times before successfully transferring Tenant #6 to the wheelchair. Staff then escorted Tenant #6 to the bathroom and transferred Tenant #6 to the toilet. After sitting briefly and without results staff placed a clean perineal-liner and replaced Tenant #6 outer clothing. During the process of redressing, and due to Tenant #6's inability to independently move upper extremities, Tenant #6's left arm became caught in Tenant #6's clothing and was next to Tenant #6's skin in the anterior perineum before staff noted it and assisted Tenant #6 to remove Tenant #6's right arm.

  Staff #2 and #3 transferred Tenant #6 to the wheelchair and escorted Tenant #6 to the community dining room table. Initially staff assisted Tenant #6 with eating, but a short time later, Staff #3 placed a portion of the sandwich in Tenant #6's hand so Tenant #6 could eat independently.

  Staff was not observed to offer or provide Tenant #6 with basic hygiene activities (perineal care and hand washing) after toileting and before eating. Tenant #6 was nonverbal and could not self-advocate nor request these activities be completed.

  Per monitor observation appropriate care, treatment and services were not provided to Tenant #6.

  - Regulatory Insufficiency: To receive care, treatment and services which are adequate and appropriate. (IAC r. 481-67.3(2))

B. Program Reporting to the Department

Complaint/Incident Allegation #47169-C: It was alleged a tenant from the dementia unit pulled the fire alarm and went outside.

- Monitoring Observation: Tenant #8, a 72 year old, was admitted on 2-1-14 and diagnoses include: Memory Loss. Tenant #8 was staged at a four on the GDS which indicated moderate cognitive decline. Tenant #8 resided in the dementia unit.

The MC Nurse was interviewed and stated Tenant #8 moved in on Saturday (2/1/14) and was a low key person. On Sunday (2/9/14) Tenant #8 went through a door that entered the AL. The door had a key pad and was not alarmed. Tenant #8 pulled a fire alarm box and exited out a back door of the AL. Staff #5 went out the building with Tenant #8 and walked Tenant #8 into the dementia unit.

Staff #5 was interviewed and stated she saw someone walking in the AL hallway that she had never seen before. She came out of the laundry room and saw Tenant #8. She called the dementia unit to find out who this person was. They said Tenant #8 was in the dementia unit. The next thing she knew, she heard the fire alarm by the exit door. She exited the building and asked the person if he was Tenant #8? Tenant #8 responded "Yes." She told Tenant #8 it was cold and they should go back into the building. Tenant #8 was fine with her and they walked around the back of the building and entered the front door of the dementia unit. Staff #5 couldn't remember what day the incident occurred but said it was before lunch. She was not sure of the time this occurred.

According to the Weather Underground at the Spirit Lake, IA airport on 2-9-14, the actual temperature was a high of 5 degrees and a low of minus 7 with no precipitation, sunny and clear.

Tenant #8 eloped from the dementia unit through an alarmed door that did not alarm. Staff in the dementia unit did not know Tenant #8 left the unit. Tenant #8 walked the entire length down the AL hallway and out an exit door next to a fire alarm box. After the fire alarm sounded, Staff #5 left the building to look for the person who pulled the alarm. The Program did not report the elopement to the Department.

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: When a tenant elopes from a program. (IAC r. 481-67.4(3))

C. Medications

Complaint/Incident Allegation #47230-C: It was alleged there was inadequate medication administration training for staff, there were frequent medication errors and medications were missing.

- Monitoring Observation:

  Tenant #10, an 87 year old, was admitted on 10-1-13 and diagnoses include: Memory Loss. Tenant #10 was staged at a four on the GDS, which indicated moderate cognitive decline. Tenant #10 resided in the dementia unit.

Tenant #10 had an order for Calcium 500 mg and Vitamin D 200 units give one tablet by mouth twice daily at 8:00 a.m. and 8:00 p.m. The Med Assist Monthly document for March 2014 indicated on 3-1-14 at 8:15 p.m. the medication was not in the medication cart. Tenant #10 had an order for Sertraline HCL 100 mg by mouth daily at 8:00 p.m. The Med Assist Monthly document for March 2014 indicated on 3-1-14 at 8:15 p.m. the medication was not in the medication cart. Tenant #10 had an order for Risperdal 0.5 mg by mouth daily at 8:00 p.m. The Med Assist Monthly document for December 2013 indicated there were 10 entries from 12-2-13 to 12-22-13 where Risperdal was not in the pill box. Tenant #10 had an order for Calcium 500 mg and Vitamin D 200 units give one tablet by mouth twice daily at 8:00 a.m. and 8:00 p.m. The Med Assist Monthly document for November 2013 indicated there were 8 entries from 11-18-13 to 11-29-13 where Calcium was not in the pill box. Tenant #10 had an order for Colace 100 mg by mouth daily. The Med Assist Monthly document for November 2013 indicated there were 2 entries where Colace was not in the pill box.

Staff #4 stated medication training included the Nurse observing two medication passes. Staff #6 stated medication training lasted for two days. Staff #7 stated the Nurse spent two to three days training her on medications and the she spent a couple days with Staff #10. She didn't feel comfortable with passing medications so she opted out after she had a medication error. Staff #8 stated medication training was provided for as much time as was needed. Staff #9 stated she spent two mornings with the Nurse. The Nurse demonstrated the process once and then watched Staff #9. The MC Nurse stated staff spent two days with the Nurse or with her for medication training. The Nurse stated medication training was two days of med passes and going over policies and topical ointments or medications. She did the first pass to demonstrate and staff did the next med pass. If staff asked they would get more training.

Staff #1 stated she hadn't seen any medication errors. Staff #4 stated she didn't know how often medication errors occurred. Staff #6 stated it was very rare for medication errors to occur in the dementia unit. Staff #7 said medication errors did not occur very often. Staff #8 stated there was only one medication error that she was aware of, the error happened when the medications were given to the wrong tenant. Staff #9 said medication errors did not occur very often.

The Nurse stated medication errors did not occur that often since installation of the medication system in 2011. The MC Nurse stated she was only aware of one medication error. The ED stated medication errors hardly occurred.

Staff #1 stated medications were rarely missing. Staff #4 stated medications were not missing very often but the day before Tenant #8's Darvocet was empty. Staff #6 stated sometime medications didn't come in right away. Staff #7 stated medications were not missing very often. Staff #8 said every once in a while a cassette was not there. She would call the nurses and they usually knew what was going on or the pharmacy was taking care of it. Staff #9 said she didn't pass medications that often but the previous week a tenant was missing two pills so she called the MC Nurse who told her to take them out of an old box that was being returned. The Nurse said medications were not missing and the ED stated medication was never missing.

Review of medication documents and staff interviews revealed medication training was routinely two days, medications were missing and medication errors did occur.

During the course of the investigation, the following information was obtained:

Monitoring Observation: Tenant #10's file was reviewed. According to the February 2014 Medication Administration Record (MARs) Calcium 500 mg + Vitamin D 200 units give one tablet by mouth twice daily at 8:00 a.m. and 8:00 p.m. On the 8:00 p.m. dose there was a written note that had read chewable which was crossed through and then crush and put with rest of meds was recorded. A doctor's order to crush medications was not found.

The table below represents lack of documented results for as needed medications and medications not documented as administered or not administered.

TENANT	MEDICATION	DOCUMENTATION ON THE MEDICATION SHEET
Tenant #9	Ativan 1 mg by mouth may have up to three times a day as needed for anxiety	2-13-14, 2-20-14, 2-26-14 and 2-27-14 documented as given under the Special Remarks; however, the effectiveness of the as needed medications was not documented
Tenant #9	Ativan 1 mg by mouth may have up to three times a day as needed for anxiety	2-12-14 documented on the MAR; however, not documented on the Special Remarks section including reason for administration and effectiveness of the as needed medication
Tenant #9	Vitamin D 50000 International Units (IU) by mouth on Friday	2-14-14 and 2-28-14 not documented as administered or not administered
Tenant #10	Tylenol 325 mg give one to two tablets by mouth every 4 hours (listed as an as needed medication)	1-21-14 and the entry indicated 1-500 mg tab for headache. The effectiveness of the medication was not documented

Tenant #12, a 74 year old, was admitted on 12-14-13 and diagnoses include: Memory Loss. A Physician order dated 1-30-14 indicated Bacitracin Zinc-Polymyxin B Ointment one application topically two times per day to apply to groin incisions after perineal-care. Tenant #12 was to return for follow-up appointment on 2-5-14. Under Special Instructions, it was noted to apply Bacitracin two times a day and as needed to incisions to prevent infection and keep incisions from getting dry and irritated. MARs for January, February and March 2014 were reviewed. From 1-30-14 at 8:00 p.m. through 2-4-14 at 8:00 p.m. Bacitracin topical twice a day was documented as administered. Starting 2-7-14 through 3-5-14, Bacitracin by mouth was documented as administered two times per day. An interview with a pharmacist for Tenant #12 indicated Bacitracin was available as an ointment or an injectable but was not available in an oral form. The order was reflected on the MARs as twice a day; the as needed application under Special Instructions was not clarified or reflected on the MAR.

Review of tenant files and MARs indicated lack of effectiveness for as needed medications, medications not being administered, medications not correctly identified on the MARs and physician medication orders not being followed or correctly identified.

- Regulatory Insufficiency: When medications are administered traditionally by the program: The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by certified and noncertified staff in accordance with subrule 67.9(4) or a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). (IAC r. 481-67.5(6)(a))

D. Staffing

Complaint/Incident Allegation #47230-C: It was alleged the personal emergency response system did not function appropriately when a tenant had an emergency situation.

- Monitoring Observation: Tenant #18, a 90 year old, was admitted on 9-27-09 and diagnoses include: Cognitive Impairment, Diverticulitis, Degenerative Joint Disease, Hyperlipidemia and HTN. Tenant #18 said Tenant #18 had a slight stroke before Christmas Eve and called staff for assistance.
  Tenant #18 was informed the call system was turned off and not turned back on. There was a button in the nurse's office that had to be turned on. Tenant #18 was unable to move or get out of bed. Eventually Tenant #18 was able to contact Tenant #18's family who called the police. The police arrived at the Program and notified staff Tenant #18 needed assistance.

According to the Resident Notes-Nurse dated 12-24-13 at 10:39 a.m., the Nurse received a phone call from the Program that Tenant #18 was having chest pains and was sent to the ER for evaluation. Tenant #18 was admitted to the hospital for observation to rule out a Myocardial Infarction (MI). Tenant #18 returned to the Program with new orders. The MI was ruled out.

Staff #9 stated there was one weekend when the call system was not working. It was last month and the Program was waiting for a part to fix it. Staff #4, #6 and #8 said the call system worked. Staff #1 said the call system worked but she heard there was a time before she was hired when it did not work. Staff #7 said the call system worked and it was checked regularly. The Nurse said there was one time on a weekend when they thought the call system was down but the computer was rebooted and then it worked. The ED stated there was one weekend when the tenants thought the system was down but is wasn't. The Maintenance Director had ordered a new cord for a computer and thought the system might go down but the system never went down. Tenants were not advised of this situation.

The Program provided a document that reflected Tenant #18's pendant calls. The document indicated three pendant calls between 12-17-13 and 12-24-13. On 12-23-13, Tenant #18 activated the Pendant at 8:46 p.m. Response time was indicated as 59.02 minutes after activation.

The Program provided a document titled Phone Log 2014. According to the ED after the 12-23-13 incident a system was established to check the phone system daily to make sure it was working. The document indicated each day from 1-1-14 through 1-12-14 a staff initial that the system had been checked.

Per file review, Tenant #18's interview, staff interviews and Program documents, the call system failed to work appropriately and Tenant #18 did not have access to notify staff of an emergency situation.

- Regulatory Insufficiency: In addition to the general staffing requirements in rule 481-67.9(231 B, 231 C, 231D), the following requirements apply to staffing programs. Each tenant shall have access to a 24-hour personal emergency response system that automatically identifies the tenant in distress and can be activated with one touch. (IAC r. 481-69.29(1))

Complaint/Incident Allegation #47230-C: It was alleged a tenant eloped from the dementia unit and set off the fire alarms. It was alleged staff on duty did not know what to do.

- Monitoring Observation: Tenant #8, a 72 year old, was admitted on 2-1-14 and diagnoses included: Memory Loss. Tenant #8 was staged at a four on the GDS which indicated moderate cognitive decline. Tenant #8 resided in the dementia unit.

According to Resident Notes-Nurse dated 2-10-14 at 4:38 p.m., on 2-9-14 the MC Nurse received a call from the dementia unit. Tenant #8 continued to have exit seeking behaviors. Tenant #8 refused morning medications stated Tenant #8 only needed one. Tenant #8 told staff to pick one and that was the one Tenant #8 would take. The staff gave Tenant #8 Lorazepam. Staff re-approached approximately 30 minutes later and Tenant #8 refused again. After breakfast Tenant #8 set off the door alarm and walked into the entry way. It took three staff to get Tenant #8 to come back into the building. Tenant #8 became physically and verbally abusive toward staff at that time. At approximately 10:35 a.m. Tenant #8 made it to the AL side of the building and pulled a fire alarm, then proceeded to run out of the building. Staff followed and was able to get Tenant #8 back in the building after he ran around the outside of the building. At 11:00 a.m. the MC Nurse was able to get Tenant #8 to take the 8:00 a.m. medications. Tenant #8 settled and after lunch laid down for a nap. No further behaviors were noted on 2-9-14.

The MC Nurse was interviewed and stated Tenant #8 moved in on Saturday and was a low key person. Tenant #8 had exited the building several times. The first time Tenant #8 pushed staff, she was between Tenant #8 and the door. The door opened and the both went outside into the parking lot. The next time Tenant #8 left the building and walked to the hardware store. Staff was with Tenant #8 the entire time. She stated the Program was not adequately staffed to handle Tenant #8's exit seeking. During the week there were four UW's (Universal Workers) on the day shift, plus an AD, a MC Nurse and a MC Coordinator. On the weekends there are only three staff on days and three staff on evenings. On Sunday Tenant #8 went through a door that entered the AL. The door had a key pad and was not alarmed. Tenant #8 pulled a fire alarm box and exited out a back door of the AL. Staff #5 went out the building looking for the person that pulled the alarm and located Tenant #8. Staff #5 identified Tenant #8 and walked Tenant #8 back into the dementia unit.

Staff #5 was interviewed and stated she saw someone walking in the AL hallway that she had never seen before. She came out of the laundry room and saw Tenant #8. She called the dementia unit to find out who this person was. They said Tenant #8 was in the dementia unit. The next thing she knew, she heard the fire alarm by the exit door. She exited the building and asked the person if he was Tenant #8? Tenant #8 responded "Yes." She told Tenant #8 it was cold and they should go back into the building. Tenant #8 was fine with her and they walked around the back of the building and entered the front door of the dementia unit. Staff #5 couldn't remember what day the incident occurred but said it was before lunch. She was not sure of the time this occurred.

Staff #9 was interviewed and stated she was working when the fire alarm sounded when Tenant #8 exited the Program. She stated she was shook up and didn't know what to do. She looked at the fire box and didn't know how to turn it off. She called the Maintenance Director who came in about 10 to 15 minutes later to turn it off.

The Maintenance Director was interviewed and stated he was not at the Program when the fire alarm sounded. He was called and told the fire box was going off. He told the staff to do what they had been trained to do. He called the Communication Center to see if he could get the call canceled. He was able to cancel the fire department but the police department came to the Program. He arrived about 15-20 minutes later and the alarm was silenced. The pulse station still needed to be reset.

Nine staff files were reviewed. Eight of the nine staff was direct care staff. Staff #1, #6, #7, #8, #9, #11, #12 and #13's files was reviewed. Staff #1, #6, #7, #8, #9, #11, #12 and #13 had documented training on fire safety.

When the fire alarm sounded, staff on duty did not know what to do in order to implement fire safety and emergency procedures.

- Regulatory Insufficiency: All program staff shall be able to implement the accident, fire safety, and emergency procedures. (IAC r. 481-67.9(2))

During the course of the investigation, the following information was obtained:

- Monitoring Observation: A medication pass was observed on 3-12-14 at 3:41 p.m. Staff #1 prepared medications for Tenant #2. As Staff #1 removed Carbido-Levodopa 25/100 from the bubble pack to place in a medication cup, the tablet dropped on the top surface of the medication cart. Staff #1 used bare hands to pick up the medication and placed it in the medication cup. Staff #1 used a hand sanitizer after the medication was picked up and before administering the medications to Tenant #2. According to the MARs, the medication was to be administered at 5:00 p.m. According to the Program, medications could be administered up to one hour prior to or one hour after the designated time of the medication. The medication was administered outside the time frame established by the Program.

  Observation of medication passes for three more tenants were performed between 3:41 P.M. and 3:50 P.M. All medications were reflected as needing to be administered at 5:00 P.M. All medications passed were completed prior to the time frame established by the Program.

  According to the medication administration training documentation for Staff #1, the Nurse completed training on proper hand washing and medication protocol including washing hands prior to and after administration of medications.

  Observation of a medication pass revealed staff touched a medication with bare hands and medications for four tenants were administered prior to the time frame established by the Program.

- Regulatory Insufficiency: The program's registered nurse shall ensure certified and noncertified staff is competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: Services shall be provided to tenants in accordance with the training provided. (IAC r. 481-67.9(4))

Complaint/Incident Allegation #47230-C: It was alleged staff were told to give insulin shots to a tenant who was diabetic and received sliding scale insulin. It was alleged staff did not have training to administer insulin and perform glucometer checks.

- Monitoring Observation: Nine staff files were reviewed. Eight of the nine staff was direct care staff. Staff #1, #6, #7, #8, #9, #11, #12 and #13's files was reviewed. The Former Activity Director's (AD) file was also reviewed. The Former AD had a nurse delegation document signed by the Nurse regarding blood glucose monitoring dated 4-5-13. The Former AD signed a Medication Administrations Check off document, which listed the six rights of administration, overseeing insulin administration, eye drops, ear drops, oral medications, as needed medications, charting on the MAR, accu-checks, topical cream/ointments, inhaled medications and contacting the RN. The Nurse also signed the document. There was no date on the form.

  The Former AD was interviewed and stated she/he never had any medication training and no delegations regarding medication administration. She/he stated as the AD she/he would transport tenants on outings to a casino every other Wednesday. On those days she/he would find a bag of medications, an insulin pen and a glucometer on the desk when she/he would arrive at work. She/he asked Staff #10 what they were for and was told they were the medications for the tenants going on the outing on that day. She/he asked the Nurse what she/he was supposed to do and the Nurse stated Tenant #17 would pull up shirt and she/he should give the insulin in Tenant #17's stomach. Staff #10 made out a sheet of paper indicating where the blood sugar was and showed her/him how to use a glucometer for the sliding scale insulin. Oral medications were in planners that included seven days with medications only in the slot for that day. The tenant's name was on the planner. She/he was told to put the medications in the tenants' hand and have them take them. She/he was never provided with gloves when she/he asked if she/he should use gloves. She/he finally told Staff #10 she/he was taking some gloves. She/he placed the used insulin needle in her/his bag and would bring it back to the Program until one day when she/he saw a container on the wall at the casino and figured she/he could put the used needles in it. Once a month the Nurse would tell her/him to sign her/his name on a sheet of paper on a clip board. She/he never signed a MAR. She/he would return the medication planners and insulin pen to the Nurse's desk when she/he returned from the outing. She/he would put the bag of medications and insulin on the floor of the bus near a heater. She/he later asked if that was okay because she/he had heard that insulin needed to be refrigerated. She/he never received any answers or direction to her/his questions.

  Per file review the Former AD was trained on overseeing insulin administration and glucometer checks. The Former AD stated she/he was instructed to administer insulin and perform glucometer checks and was not trained.

- Regulatory Insufficiency: Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status. (IAC r. 481-67.4(d))

During the course of the investigation, the following information was obtained:

- Monitoring Observation: The MC Nurse was interviewed and stated she/he trained all staff that worked in the dementia unit and she/he completed delegations for dementia unit staff.

  The Nurse was interviewed and stated she/he had not completed delegation training for the MC Nurse because she felt it fell under the MC Nurse's scope of practice as an RN. She/he started to say "under the new rules" then stopped and acknowledged, "Oh, the rules say I need to train her."

  When there are multiple delegating nurses, the delegating nurse who completed the training shall train the other delegating nurse. The Nurse had not trained the MC Nurse in regards to delegations.

- Regulatory Insufficiency: All programs employing a new delegating nurse after January 1, 2010, shall require the delegating nurse within six months of hire to complete an assisted living manager class or assisted living nursing class whose curriculum includes at least six hours of training specifically related to Iowa rules and laws on assisted living. A minimum of one delegating nurse from each program must complete the training. If there are multiple delegating nurses and only one delegating nurse completes the training, the delegating nurse who completes the training shall train the other delegating nurses in the Iowa rules and laws on assisted living. As of January 1, 2011, all programs shall have a minimum of one delegating nurse who has completed the training described in this subrule. (IAC r. 481-69.29(6))

Complaint/Incident Allegation #47230-C: It was alleged a tenant fell out of bed, sustained an injury, needed assistance eating and did not always receive assistance with eating.

- Monitoring Observation: Tenant #17, an 80 year old was admitted on 3-21-08 and diagnoses included: Insulin Dependent Diabetes Mellitus and Bipolar Disorder.

  According to Resident Notes-Nurse dated 2-6-14 at 9:15 a.m., the Nurse was called to Tenant #17's room. Tenant #17 stated Tenant #17 had fallen out of bed. She asked Tenant #17 if Tenant #17 had reported to anyone about the fall. Tenant #17 responded, "No." Tenant #17 complained of right wrist pain, swelling around the right wrist was noted and tender to touch. Tenant #17 was able to move fingers up and down but stated it hurt too much to move the wrist. Tenant #17 was sent to the Emergency Room (ER) for evaluation and returned with a fracture and a splint.

  According to Physician Orders dated 2-6-14 Tenant #17 had a non-displaced fracture of the distal ulna. A splint was applied and could be adjusted as needed; ice as needed and may open splint to use ice.

  According to the Service Plan dated 2-6-14, Tenant #17 needed some help with feeding and meal set up (cutting up foods, etc.) Weighted silverware was used.

Staff #1 and #9 stated there were no tenants who needed assistance with eating. Staff #7 stated Tenant #17 needed assistance for a while when Tenant #17's dominate wrist was in a cast, and assistance was provided. Staff # 4, #6 and #8 stated there were tenants in the dementia unit that needed assistance with eating. The Nurse stated Tenant #17 needed assistance eating and did receive the assistance when needed. The ED stated they did not currently have anyone who needed assistance with eating but they did assist Tenant #17 when help was needed.

Tenant #17 was deceased and not able to be interviewed.

Per Tenant #17's file review and staff interviews, assistance with eating was provided when needed.

- Regulatory Insufficiency: None noted.

E. Evaluation

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Tenant #6's file was reviewed. According to a hospice nursing assessment dated 3-10-14, Tenant #6 was incontinent of urine at all times. Tenant #6 was sleeping more which caused Tenant #6 to skip meals. Tenant #6 was total assistance with cares and feeding. According to the hospice update to comprehensive plan of care dated 03-12-14, Tenant #6 continued to be non-verbal, was more difficult to arouse at times, spent more time sleeping; leaned further to the right in the wheelchair and a hospital bed with side rails was ordered. It also indicated Tenant #6 required full assistance with meals and occasionally slept through meals which was different compared to two months ago. Tenant #6 was unable to hold Tenant #6's head up, was very weak and required full assist with food and fluids. A personal alarm was used at all times. Tenant #6's positioning had gotten worse in the wheelchair.

  A Clinical Update Summary and cognitive evaluation were completed on 3-7-14. The evaluations were updated on 3-7-14; however, did not reflect the care needs as identified in hospice documentation. Evaluations were not completed as needed.

  Tenant #9, an 83 year old, was admitted on 11-18-11 and diagnosis included: Dementia. Tenant #9 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #9 resided in the dementia unit.

  According to a MD Visit/Contact document dated 12-16-13, Tenant #9 had been more confused lately and easily upset. A scant amount of blood was noted in the protective undergarment that afternoon. The urine had a foul odor. A Urinalysis with Culture and Sensitivity was ordered. Ciprofloxacin 500 mg by mouth twice daily for five days was ordered and Bactrim DS by mouth twice daily for seven days was ordered on 12-24-13.

According to a MD Visit/Contact document dated 1-16-14, Tenant #9 became violent when staff attempted to put on anti-embolism hose and then refused. Tenant #9 reported they hurt to put on and Tenant #9 would not wear them. An order for edema wear was requested and the doctor ordered. The order was noted 1-16-14.

According to a MD Visit/Contact document dated 2-12-14, staff reported Tenant #9 had become increasingly difficult to shower over the last two weeks. When the shower was occurring Tenant #9 yelled, cried out and was violent with staff. The behavior occurred as Tenant #9 dug frantically in Tenant #9's perineal area with both hands and yelled. An as needed medication 30 to 60 minutes before showering was administered without results. A UA with culture was ordered. The order was dated 2-13-14.

According to Resident Notes-Nurse dated 2-18-14, a 90 day assessment was completed. Tenant #9 had no incidents in the last review period. Tenant #9 continued to receive toileting assistance, well-being checks, dressing assistance, shower assistance, laundry services, housekeeping services, three meals per day, medication administration and escort services.

According to an Incident Report, on 2-28-14 at 4:00 p.m. staff found Tenant #9 on the floor and Tenant #9's face was swelling. Staff got the nurse right away. The fall was not witnessed. Tenant #9 had a laceration, bruising and swelling noted to the head or face. According to the report, 911 was called.

According to hospital Discharge Instructions, the title of the education sheet given was Subarachnoid Bleed-Brain Bleed.

According to Resident Notes-Nurse dated 2-28-14, Tenant #9 was transferred to the ER for assessment post fall. Resident Notes-Nurse dated 3-1-14 indicated Tenant #9 was admitted for observation after the ER evaluation on 2-28-14. Tenant #9 came back to the building via ambulance. A nurse review was completed. A follow up assessment was completed. The right eye was swollen shut, there was bruising around both eyes and down the face into the neck. Staff was instructed to call the nurse immediately if Tenant #9 had nausea/vomiting, headache unrelieved with Tylenol, mental status change or increased confusion.

According to Resident Notes-Nurse dated 3-3-14, a 90 day assessment was completed. Tenant #9 had one incident in the last review period. Tenant #9 continued to receive well-being checks, dressing assistance, escort services, laundry services, housekeeping services, medication administration, shower assistance and toileting assistance.

According to Resident Notes-Nurse dated 3-11-14, Tenant #9 was out and back to the doctor and there were no new orders.

According to a MD Visit/Contact document dated 3-11-14, there was a follow up visit for a head injury. The doctor ordered to monitor neurological checks daily for two weeks and notify for any new concerns. The order was noted 3-11-14.

A Clinical Update Summary (annual assessment), Mental Status Questionnaire and GDS were completed on 11-18-13. A Service Plan was also completed on 11-18-13. A Clinical Update Summary (90 day assessment), Mental Status Questionnaire and GDS were completed on 2-18-14. A Summary (nurse review) was completed on 3-1-14. A Clinical Update Summary (90 day assessment), Mental Status Questionnaire and GDS were completed on 3-3-14. The evaluations, although completed at various intervals did not reflect UTIs, behavior during showers, behavior towards staff regarding the anti-embolism hose or the brain bleed that occurred with a fall on 2-28-14. Evaluations were not completed as needed. Tenant #10's file was reviewed. According to a MD Visit/Contact document dated 12-26-13, staff reported Tenant #10 had become aggressive and at times violent toward staff and threatening bodily harm to them. Tenant #10 was tearful and more confused. Tenant #10 was swearing at staff and redirection was not possible for the last two days. The doctor ordered a UA, urine culture and psychiatry consult. The order was noted on 12-27-13.

According to an Incident Report, on 12-26-13 staff walked into Tenant #10's apartment and found Tenant #10 lying on the floor in front of the closet on the left side. Tenant #10 complained of left hip and shoulder pain and hit Tenant #10's head. According to the report, 911 was called. According to Resident Notes-Nurse dated 12-27-13, paramedics arrived and Tenant #10 refused to go and denied any pain.

According to Resident Note-Nurses dated 12-30-13, on 12-29-13 Tenant #10 was transferred to the ER via ambulance for a four inch skin tear to the left arm. The tear was repaired with Dermabond. Tenant #10 returned to the Program via private vehicle with instructions to return if wound opened or showed signs of infection.

A Clinical Update Summary (30 day assessment), Mental Status Questionnaire and GDS were completed on 11-1-13. A Clinical Update Summary (90 day assessment), Mental Status Questionnaire and GDS were completed on 1-2-14. A Clinical Update Summary was completed on 1-2-14; however, did not reflect the aggressive and at times violent behavior, increased confusion and swearing at staff. Evaluations were not completed as needed.

Review of tenant files indicated evaluations were not completed as needed.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

F. Criteria for Admission and Retention

Complaint/Incident Allegation #47230-C: It was alleged tenants exceeded level of care but were not moved to the dementia unit

- Monitoring Observation: Eighteen tenant files were reviewed. Staff #7 stated Tenant #5's memory was declining and the nurses were working towards transferring Tenant #5 to the dementia unit. Staff #9 stated Tenant #5 was confused and needed to live in a dementia unit. The Nurse stated Tenant #5 would be moving to the dementia unit as soon as a room was open. The ED stated Tenant #5 was confused and needed to move to the dementia unit and she had spoken to Tenant #5's family about transferring.

  Tenant #5, a 90 year old, was admitted on 08-14-13 and diagnoses include: HTN, Atrial Fibrillation, Anemia and Memory Loss. Tenant #5 was staged at a five on the GDS, which indicated moderately severe cognitive decline. According to a service plan dated 12-1-3 Tenant #5 was independent with eating, mobility, activities and required reminders for bathing, grooming, dressing and toileting.

  On 3-12-14 at 7:10 p.m. Tenant #5 was observed. Tenant #5 ambulated independently in the apartment and was dressed appropriately. Tenant #5 was polishing silver spoons at the time of the observation. Tenant #5 engaged in conversation; however, was not able to completely communicate a response to the monitor.

  Review of Tenant #5's file, staff interviews and monitor observation indicated Tenant #5 did not exceed the criteria for admission and retention; however, a transfer to the dementia unit was being discussed and planned.

  - Regulatory insufficiency: None noted.

  During the course of the investigation, the following information was obtained:

- Monitoring Observation: Tenant #6's file was reviewed. Review of the service plan dated 12-9-13, indicated Tenant #6 required full staff assistance with bathing, with little or no participation from Tenant #6. Tenant #6 also required full help dressing and undressing, eating, grooming and hygiene including perineal care, turning and repositioning and wheel chair mobility. Tenant #6 did not ambulate.

  Monitor observation on 3-12-14 at 5:02 p.m. revealed Staff #2 and #3 entered Tenant #6's apartment and left the door to the apartment wide open. Staff approached Tenant #6 and called Tenant #6 by name. Tenant #6 did not respond or open Tenant #6's eyes. Staff #3 gently touched Tenant #6's face, while calling Tenant #6's name and informed Tenant #6 what they were going to do. Staff donned gloves and lowered the foot rests of the recliner chair and attempted a pivot transfer to the wheelchair. Tenant #6 could not/did not stand, and staff demonstrated difficulty in the transfer with Tenant #6's knees almost touching the floor. Staff #2 and #3 attempted a second transfer, that time successful in assisting Tenant #6 to the wheelchair.

Staff escorted Tenant #6 to the bathroom and transferred Tenant #6 to the toilet. After sitting briefly and without results staff placed a clean peri liner and replaced Tenant #6's outer clothing.

Staff #4, #8, the Nurse and the Memory Care Nurse stated Tenant #6 was a routine two person assist.

Staff #2 was interviewed on 03-12-14 at 4:45 p.m. and stated Tenant #6 required the assistance of two staff for everything; all activities of daily living. Staff #2 stated Tenant #6 did not stand, but staff just lifted Tenant #6 when transferring Tenant #6. Staff #2 also stated Tenant #6 did not feed himself/herself. Staff #2 stated staff documented tenant checks every two hours.

Tenant #6's file was reviewed. According to a hospice nursing assessment dated 3-10-14, Tenant #6 was incontinent of urine at all times. Tenant #6 was sleeping more which caused Tenant #6 to skip meals. Tenant #6 was total assistance with cares and feeding. According to the hospice update to comprehensive plan of care dated 03-12-14, Tenant #6 continued to be non-verbal, was more difficult to arouse at times, spent more time sleeping; leaned further to the right in the wheelchair and a hospital bed with side rails was ordered. It also indicated Tenant #6 required full assistance with meals and occasionally slept through meals which was different compared to two months ago. Tenant #6 was unable to hold Tenant #6's head up, was very weak and required full assist with food and fluids. A personal alarm was used at all times. Tenant #6's positioning had gotten worse in the wheelchair.

The Program applied for a Waiver of Administrative Rule (Health-Related) from the Department, which indicated the waiver of rule requested was for a routine two person assist with transfers and maximum assistance with ADLs.

Review of Tenant #6's file, staff interviews, review of Hospice records and the application for a Request for Waiver of Administrative Rule indicated Tenant #6 exceeded the admission and retention criteria.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: Requires routine, two-person assistance with standing, transfer or evacuation or requires maximal assistance with activities of daily living.
  (IAC r. 481-69.23(1)(b)(i))

G. Tenant Documents

Complaint/Incident Allegation #47230-C: It was alleged staff was told to destroy incident reports and to only complete incident reports when a tenant fell on the floor.

- Monitoring Observation: Eighteen tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17 and #18.). Incident reports were reviewed from November 2013 through March 2014. Tenant #11's file was reviewed. According to the Service Plan dated 8-19-13, Tenant #11 was independent with mobility and used a cane at times.

  Staff #1, #4, #6, #7 and #9 said they had not been directed to tear up incident reports. Staff # 8 stated she didn't think she'd been told to tear up incident reports. The ED and Nurse stated staff had not been told to tear up incident reports.

  Review of Tenant #11's file and review of incident reports did not reveal a fall was documented and there was no evidence staff had been directed to tear up incident reports.

- Regulatory insufficiency: None noted.

During the course of the investigation, the following information was obtained:

The MC Nurse was interviewed and stated Tenant #8 moved in on Saturday and was a low key person. Tenant #8 had exited the building several times. The first time Tenant #8 pushed staff, she was between Tenant #8 and the door. The door opened and the both went outside into the parking lot. The next time Tenant #8 left the building and walked to the hardware store. Staff was with Tenant #8 the entire time. She stated the Program was not adequately staffed to handle Tenant #8's exit seeking. During the week there were four UW's on the day shift, plus an AD, a MC Nurse and a MC Coordinator. On the weekends there are only three staff on days and three staff on evenings. On Sunday Tenant #8 went through a door that entered the AL. The door had a key pad and was not alarmed. Tenant #8 pulled a fire alarm box and exited out a back door of the AL. Staff #5 went out the building looking for the person that pulled the fire alarm and located Tenant #8. Staff #5 identified Tenant #8 and walked Tenant #8 back into the dementia unit.

Staff #5 was interviewed and stated she saw someone walking in the AL hallway that she had never seen before. She came out of the laundry room and saw Tenant #8. She called the dementia unit to find out who this person was. They said Tenant #8 was in the dementia unit. The next thing she knew, she heard the fire alarm by the exit door. She exited the building and asked the person if he was Tenant #8? Tenant #8 responded "Yes." She told Tenant #8 it was cold and they should go back into the building. Tenant #8 was fine with her and they walked around the back of the building and entered the front door of the dementia unit. Staff #5 couldn't remember what day the incident occurred but said it was before lunch. She was not sure of the time this occurred.

Tenant #8 eloped from the dementia unit without staff knowledge. Tenant #8 walked the entire length down a hallway in the AL and exited the building without staff knowledge. The Program did not complete an Incident Report regarding Tenant #8's elopement.

- Regulatory Insufficiency: Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record). (IAC r. 481-69.25(1)(o))

During the course of the investigation, the following information was obtained:

- Monitoring Observation:

Tenant #9's file was reviewed. According to a MD Visit/Contact document dated 12-16-13, Tenant #9 had been more confused lately and easily upset. A scant amount of blood was noted in the protective undergarment that afternoon. The urine had a foul odor. A UA with Culture and Sensitivity was ordered. Cipro 500 mg by mouth twice daily for five days was ordered and then Bactrim DS by mouth twice daily for seven days was ordered on 12-24-13.

According to a MD Visit/Contact document dated 1-16-14, Tenant #9 became violent when staff attempted to put on anti-embolism hose and then refused. Tenant #9 reported that they hurt to put on and Tenant #9 would not wear them. An order for edema wear was requested and the doctor ordered. The order was noted 1-16-14.

According to a MD Visit/Contact document dated 2-12-14, staff reported Tenant #9 had become increasingly difficult to shower over the last two weeks. When the shower was occurring Tenant #9 yelled, cried out and was violent with staff. The behavior occurred as Tenant #9 dug frantically in Tenant #9's perineal area with both hands. An as needed medication 30 to 60 minutes before showering was administered without results. A UA with culture was ordered. The order was dated 2-13-14.

According to an Incident Report, on 2-8-14 at 4:00 p.m. staff found Tenant #9 on the floor and Tenant #9's face was swelling. Staff got the nurse right away. The fall was not witnessed. Tenant #9 had a laceration, bruising and swelling noted to the head or face. According to the report, 911 was called.

According to hospital Discharge Instructions, the title of the education sheet given was Subarachnoid Bleed-Brain Bleed.

According to Resident Notes dated 2-28-14, Tenant #9 was transferred to the ER for assessment post fall. Resident Notes dated 3-1-14 indicated Tenant #9 was admitted on observation after the ER evaluation on 2-28-14. Tenant #9 came back to the building via ambulance. A nurse review was completed. A follow up assessment was completed.

The right eye was swollen shut, there was bruising around both eyes and down the face into the neck. Staff was instructed to call the nurse immediately if Tenant #9 had nausea/vomiting, headache unrelieved with Tylenol, mental status change or increased confusion.

According to Resident Notes dated 3-3-14, a 90 day assessment was completed. Tenant #9 had one incident in the last review period. Tenant #9 continued to receive well-being checks, dressing assistance, escort services, laundry services, housekeeping services, medication administration, shower assistance and toileting assistance.

According to Resident Notes dated 3-11-14, Tenant #9 was out and back to the doctor and there were no new orders.

According to a MD Visit/Contact document dated 3-11-14, there was a follow up visit for a head injury. The doctor ordered to monitor neurological checks daily for two weeks and notify for any new concerns. The order was noted 3-11-14.

The Resident Notes-Nurse did not reflect documentation by exception including a UTI, behavior during showers, behaviors towards staff regarding the anti-embolism hose or the brain bleed that occurred with a fall on 2-28-14. The notes did document new orders received on 12-20-13 and 12-24-13; however, the notes did not indicate what the new orders were or the reason for the order, such as a UTI. The notes did address there was a fall and admission to the hospital; however, the notes did not indicate Tenant #9 had a brain bleed.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those treatment, therapy, and medication; and nurses' notes written by exception. (IAC r. 481-69.25(1)(i))

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Tenant #6's file was reviewed. Review of the service plan dated 12-9-13, Tenant #6 required full help/assist with bathing with little or no participation from Tenant #6. Tenant #6 also required full help dressing and undressing, eating, grooming and hygiene including perineal care, turning and repositioning and wheelchair mobility. Tenant #6 did not ambulate.

Staff #2 was interviewed on 03-12-14 at 4:45 p.m. and stated Tenant #6 required the assistance of two staff for everything; all ADLs. Staff #2 stated Tenant #6 did not stand, but staff just lifted Tenant #6 when transferring Tenant #6. Staff #2 also stated Tenant #6 did not feed himself/herself. Staff #2 stated staff documented tenant checks every two hours. Staff #2 also indicated during the interview that she had not heard of nor knew what "task sheets" were.

On the inside of Tenant #6's bathroom door was a 2 hour Resident check (maybe 15 minutes before or after the 2 hour check) document. The document appeared to document Tenant #6's location, the time and initials. The check sheet did not document cares including repositioning, oral cares, personal grooming and offering fluids and food.

Documentation from the Hospice nurse on 03-12-14 indicated Tenant #6 was nonverbal and required total assistance from staff.

Tenant #6 was unable to advocate for himself/herself. An inquiry was made towards Staff related to task sheets and completion of routine personal cares, however; staff members were unable to produce such sheets.

Review of Tenant #6's file, staff interviews, Hospice documents and monitor observation indicated task sheets were not completed for Tenant #6 as required.

- Regulatory Insufficiency: When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs). (IAC r. 481-69.25(1)(q))

H. Service Plans

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Tenant #6's file was reviewed. Tenant #6's most recent service plan was dated 12-9-13. The service plan identified cares to be provided which included the following: toileting every two hours, well-being checks every two hours and assistance with bathing, dressing and eating.

Tenant #6 was observed on 03-12-14 at 4:40 p.m. At that time Tenant #6 was seated in a recliner in the room, Tenant #6's feet elevated on the foot rest. It was also noted that Tenant #6 had a personal clip alarm (device that would alarm if the tenant attempted to stand up unassisted) attached.

Observation on 3-12-14 at 5:02 p.m. revealed Staff #2 and Staff #3 approached Tenant #6 and called Tenant #6's name. Tenant #6 did not respond or open Tenant #6's eyes. Staff #3 then gently touched Tenant #6 face, while calling Tenant #6's name and informed Tenant #6 what they were going to do. With gloves on Staff #2 and Staff #3 attempted to transfer Tenant #6 to the wheelchair. Tenant #6 could not/did not stand, and staff demonstrated difficulty in the transfer with Tenant #6's knees almost touching the floor.

According to a hospice nursing assessment dated 3-10-14, Tenant #6 was incontinent of urine at all times. Tenant #6 was sleeping more which caused Tenant #6 to skip meals. Tenant #6 was total assistance with cares and feeding.

According to the hospice update to comprehensive plan of care dated 03-12-14, Tenant #6 continued to be non-verbal, was more difficult to arouse at times, spent more time sleeping; leaned further to the right in wheelchair and a hospital bed with side rails ordered.

It also indicated Tenant #6 required full assistance with meals and occasionally slept through meals which was different compared to two months ago. Tenant #6 was unable to hold Tenant #6's head up, was very weak and required full assist with food and fluids. A personal alarm was used at all times. Tenant #6's positioning had gotten worse in the wheelchair.

The service plan was last updated on 12-9-13 and did not reflect the care needs as identified in hospice documentation. The service plan did not reflect hospice services that were provided, did not reflect the use of the personal alarm, the hospital bed with side rails and a reclining wheelchair. The service plan indicated under mobility (bed; transfer) Tenant #6 needed help with transfer (one person assist), needed two people to transfer. The service plan was not updated as needed, did not reflect the identified needs and did not reflect the outside service provider.

Tenant #8's file was reviewed. According to a MD Visit/Contact document dated 1-29-14, Tenant #8 would be moving into the dementia unit on 2-1-14. Family was concerned about Tenant #8's anxiety as family reported Tenant #8 becomes uneasy, angry and restless. An order for Seroquel 25 mg. by mouth every morning was received.

According to a MD Visit/Contact dated 2-3-14, Tenant #8 started Seroquel on 2-1-14 but no difference in behaviors noted. Tenant #8 continued to be verbally abusive, physically aggressive and made multiple attempts at exiting the building. Attempts at redirection were not helpful. Tenant #8 was one on one at all times to keep in dementia unit. A new order was received for Seroquel 25 mg. by mouth twice a day.

According to the Resident Notes-Nurse Tenant #8 after breakfast Tenant #8 set off the door alarm and walked into entry way and three staff were needed to get Tenant #8 back into the building. At 10:35 a.m. Tenant #8 eloped from the AL side of the building. According to Resident Notes-Nurse dated 2-11-14, Tenant #8 had exit seeking behaviors, redirected from doors to room and carried personal belonging around wrapped in a blanket, wandering room to room asking to go home.

According to the Resident Notes-Nurse dated 2-13-14, the MC Nurse received a call at 4:40 a.m. Tenant #8 was yelling at staff and other tenants. Tenant #8 was going in and out of tenant rooms, trying to pull other tenants out of their beds, exit seeking behaviors and refused to take as needed medications. Tenant #8 was verbally and physically aggressive with staff and the staff member was unable to redirect Tenant #8.

Tenant #8's service plan dated 3-3-14 Tenant #8 had no behaviors that required intervention. Exit seeking behaviors were not indicated. Interventions for redirection were not reflected. Tenant #8's service plan was not updated as needed and did not reflect the identified needs of Tenant #8.

Tenant #9's file was reviewed. According to a MD Visit/Contact document dated 12-16-13, Tenant #9 had been more confused lately and easily upset. A scant amount of blood was noted in the protective undergarment that afternoon. The urine had a foul odor. A UA with Culture and Sensitivity was ordered.
Cipro 500 mg by mouth twice daily for five days was ordered and then Bactrim DS by mouth twice daily for seven days was ordered on 12-24-13.

According to a MD Visit/Contact document dated 1-16-14, Tenant #9 became violent when staff attempted to put on anti-embolism hose and then refused. Tenant #9 reported that they hurt to put on and Tenant #9 would not wear them. An order for edema wear was requested and the doctor ordered. The order was noted 1-16-14.

According to a MD Visit/Contact document dated 2-12-14, staff reported Tenant #9 had become increasingly difficult to shower over the last two weeks. When the shower was occurring Tenant #9 yelled, cried out and was violent with staff. The behavior occurred as Tenant #9 dug frantically in Tenant #9's perineal area with both hands. An as needed medication 30 to 60 minutes before showering was administered without results. A UA with culture was ordered. The order was dated 2-13-14.

According to Resident Notes-Nurse dated 2-18-14, a 90 day assessment was completed. Tenant #9 had no incidents in the last review period. Tenant #9 continued to receive toileting assistance, well-being checks, dressing assistance, shower assistance, laundry services, housekeeping services, three meals per day, medication administration and escort services.

According to an Incident Report, on 2-8-14 at 4:00 p.m. staff found Tenant #9 on the floor and Tenant #9's face was swelling. Staff got the nurse right away. The fall was not witnessed. Tenant #9 had a laceration, bruising and swelling noted to the head or face. According to the report, 911 was called.

According to hospital Discharge Instructions, the title of the education sheet given was Subarachnoid Bleed-Brain Bleed.

According to Resident Notes-Nurse dated 2-28-14, Tenant #9 was transferred to the ER for assessment post fall. Resident Notes dated 3-1-14 indicated Tenant #9 was admitted on observation after the ER evaluation on 2-28-14. Tenant #9 came back to the building via ambulance. A nurse review was completed. A follow up assessment was completed. The right eye was swollen shut, there was bruising around both eyes and down the face into the neck. Staff was instructed to call the nurse immediately if Tenant #9 had nausea/vomiting, headache unrelieved with Tylenol, mental status change or increased confusion.

According to Resident Notes-Nurse dated 3-3-14, a 90 day assessment was completed. Tenant #9 had one incident in the last review period. Tenant #9 continued to receive well-being checks, dressing assistance, escort services, laundry services, housekeeping services, medication administration, shower assistance and toileting assistance.

According to Resident Notes-Nurse dated 3-11-14, Tenant #9 was out and back to the doctor and there were no new orders.

According to a MD Visit/Contact document dated 3-11-14, there was a follow up visit for a head injury. The doctor ordered to monitor neurological checks daily for two weeks and notify for any new concerns. The order was noted 3-11-14.

A Clinical Update Summary (annual assessment), Mental Status Questionnaire and GDS were completed on 11-18-13. A Master Care Plan was also completed on 11-18-13. The service plan was not updated after 11-18-13. The service plan did not reflect the UTI, behavior during showers, behavior towards staff regarding the anti-embolism hose and interventions related to those issues. The service plan did not reflect the brain bleed that occurred with a fall on 2-28-14. When Tenant #9 returned from the hospital staff was instructed to call the nurse immediately if Tenant #9 had nausea/vomiting, headache unrelieved with Tylenol, mental status change or increased confusion. Those instructions related to were not reflected on the service plan. The service plan also did not reflect the orders from the follow up appointment related to the head injury regarding neurological checks daily for two weeks. The service plan was not updated as needed and did not reflect the identified needs of Tenant #9.

Tenant #10's file was reviewed. According to a MD Visit/Contact document dated 12-26-13, staff reported Tenant #10 had become aggressive and at times violent toward staff and threatening bodily harm to them. Tenant #10 was tearful and more confused. Tenant #10 was swearing at staff and redirection was not possible for the last two days. The doctor ordered a UA, urine culture and psychiatry consult. The order was noted on 12-27-13.

According to an Incident Report, on 12-26-13 staff walked into Tenant #10's apartment and found Tenant #10 lying on the floor in front of the closet on the left side. Tenant #10 complained of left hip and shoulder pain and hit Tenant #10's head.

According to the report, 911 was called. According to Resident Notes-Nurse dated 12-27-13, paramedics arrived and Tenant #10 refused to go and denied any pain. According to Resident Notes-Nurse dated 12-30-13, on 12-29-13 Tenant #10 was transferred to the ER via ambulance for four inch skin tear to the left arm. The tear was repaired with Dermabond. Tenant #10 returned to the Program via private vehicle with instructions to return if wound opened or showed signs of infection.

A Clinical Update Summary (30 day assessment), Mental Status Questionnaire and GDS were completed on 11-1-13. A Master Care Plan was completed on 11-1-13.

A Clinical Update Summary (90 day assessment), Mental Status Questionnaire and GDS were completed on 1-2-14. The service plan was not updated as needed and did not reflect the aggressive and at times violent behavior, increased confusion and swearing at staff. The service plan did not reflect Tenant #10 had falls and interventions related to the falls. The Master Care Plan was signed by the Nurse and the ED on 11-1-13. A note indicated it was mailed on 11-1-13 and they were waiting for signatures.

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC r. 481-69.26(3))

- Regulatory Insufficiency: If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. (IAC r. 481-69.26(3)(a))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

- Regulatory Insufficiency: The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy. (IAC r. 481-69.26(4)(c))

J. Nurse Review

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Tenant #8 eloped from the Program. According to Resident Notes-Nurse, an entry dated 2-10-14, indicated on 2-9-14 the MC Nurse received a call from the dementia unit. Tenant #8 continued to have exit seeking behaviors.

  On 2-9-14 Tenant #8 refused morning medications stated Tenant #8 only needed one. Tenant #8 told staff to pick one and that was the one Tenant #8 would take. The staff gave Tenant #8 Lorazepam. Staff re-approached approximately 30 minutes later and Tenant #8 refused again. After breakfast Tenant #8 set off the door alarm and walked into the entry way. It took three staff to get Tenant #8 to come back into the building. Tenant #8 became physically and verbally abusive toward staff at that time. At approximately 10:35 a.m. Tenant #8 made it to the AL side of the building and pulled a fire alarm, then proceeded to run out of the building. Staff was able to get Tenant #8 back in the building after he ran around the outside of the building. At 11:00 a.m. the MC Nurse was able to get Tenant #8 to take the 8:00 a.m. medications. Tenant #8 settled and after lunch laid down for a nap. No further behaviors were noted on 2-9-14.

Tenant #8's file did not reflect a nurse assessment completed after Tenant #8 exited the building and was outside.

Review of Tenant #8's file did not indicate a nurse review was completed.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

I. Food Service

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Menus were provided for the period of December 30, 2013 through March 23, 2014. The menus reflected Lunch and Supper as well as a Second Choice for each of those meals. A note attached to the menus indicated breakfast was served as a continental meal. The majority of the Second Choices for lunch indicated a specific type of soup or specific sandwich. The Second Choice for the Supper meal stated Soup OR Salad. Three times during this period the second choice at supper was listed as soup only and eight times the second choice was only listed as chef salad. Multiple choices were not available. A review of the menus revealed chips or assorted chips were served 23 times as part of the main meal, not counting the second choice meals.

  Monitor observation on 03-12-14 at 5:35 p.m. of the supper meal in the dementia unit revealed all Tenants were served the meal on white plates, and menu items included a taco burger (meat on plain white hamburger bun), potato chips and diced pears. Tenants were served milk, water, coffee and /or tea to drink.

  An announcement was made at the noon meal inviting all tenants to a community meeting later that afternoon. A community meeting was held with 10 tenants and 1 family member and private interviews were held with 2 tenants and 1 family member. The tenants stated the food was terrible. It was advertised as "Chef Inspired" but the person cooking the food was not a chef. Tenants stated the food was too salty, low quality and meet was tough. Cookies were hard and tenants had been told to either dunk them in coffee or microwave them. Hot foods were not served hot and substitutions were not available. Staff was more concerned about taking the food order than helping the tenants who needed assistance. Three tenants stated they liked the food.

The ED was interviewed and stated they did not always follow the menu. The name of the food vendor was provided. The ED was asked to provide a copy of the menus signed by a Registered Dietician (RD) but was unable to provide proof of RD review.

The Territory Manager of the food service vendor was interviewed. He confirmed the Program purchased their food from the company. He stated the company purchased the previous food company in October 2012 and at that time took the menus provided by the previous food company and set the menus up as a separate entity in order to continue to use the menus. The current food service vendor did not employ an RD as the programs who obtained their food from the food service vendor were supposed to have a consulting dietician or their own onsite dietician. It was his understanding that the Program had a consulting dietician. He stated the Program called him on 3-13-14 and requested nutritional information for the menus. He stated the Program told him they do not always follow the menus as they have made meals per tenant request.

Review of menus, observation of a supper meal, community meeting comments and interviews with the ED and Territory Manager indicated the Program did not provide meals that met the daily recommended dietary allowances and did not have menus reviewed by a dietician.

- Regulatory Insufficiency: Menus shall be provided to provide the following percentage of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences based on the number of meals provided by the program: A minimum of 66 2/3 percent if the program provides two meals per day. (IAC r. 69.28(3)(b)).

- Regulatory Insufficiency: Programs may have an on-site dietician. Programs may secure menus and a dietician through other methods. (IAC r. 481-69.28(7))

J. Dementia-Specific Education

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Nine staff files were reviewed. Eight of the nine staff was direct care staff. Staff #1, #6, #7, #8, #9, #11, #12, #13's files were reviewed. The dementia training documentation that was provided consisted of web training, reading manual and videos. There was no documentation of any hands-on dementia training. The Program had a dementia unit with 23 tenants, 22 of which had a GDS score of four or greater.

  Review of staff files indicated the Program did not provide hands-on dementia specific-training as part of the dementia training.

- Regulatory Insufficiency: Dementia-specific training shall include hands-on training and may include any of the following: classroom, instruction, Web-based training, and case studies of tenants in the program. (IAC r. 481-69.30(5)).

K. Life Safety

During the course of the investigation, the following was obtained:

- Monitoring Observation: Tenant #8 exited the dementia unit via a door that used a key pad alarm and was attached to the AL. The Maintenance Director was interviewed and stated since building construction had started in the dining room near the exit door; a vacuum of air was created between the latch on the door and the closure. The door did not always automatically shut and would need to be manually pulled closed to latch. After Tenant #8 exited the dementia unit and left the building he fixed the latch and there had not been any further issues.

  The door between the dementia unit and the AL was not alarmed, only a key pad was used for exiting the dementia unit. To enter the dementia unit, a single button was pushed to release the door.

  The existing door closure did not function appropriately which resulted in Tenant #8's elopement from the Program. The door was not alarmed with the appropriate operating system.

- Regulatory Insufficiency: An operating system shall be connected to each exit door in a dementia-specific program. A program serving a person(s) with cognitive disorder or dementia, whether in a general or dementia-specific setting, shall have: Written procedures regarding alarm systems and appropriate staff response when a tenant's service plan indicates a risk of elopement or a tenant exhibits wandering behavior. Written procedures regarding appropriate staff response if a tenant with cognitive disorder or dementia is missing. (IAC r. 481-69.32(2)(a)(b))

L. Structural Requirements

During the course of the investigation, the following information was obtained:

- Monitoring Observation: During the investigation on 3-12-14, observation of the kitchenette in the dementia unit at 5:48 p.m. indicated the following:

  Located in an unlocked cupboard was a 33.8 fluid ounce container (9/10 full) of a foaming hand sanitizer. The container was labeled with a warning to keep out of reach of children. The Material Safety Data Sheet (MSDS) described the following warnings: Skin: Excessive exposure may cause irritation or dryness; Eyes: May cause temporary irritation and Ingestion: In large quantity, may result in vomiting or diarrhea. Located next to the sink was a 2 liter bottle (3/4 full) of hand sanitizer. Also, a full 2 liter bottle was located in an unlocked cupboard under the sink. The container was labeled with a warning for External Use Only. The MSDS described the following warnings: Keep out of reach of children; Inhalation: May cause irritation of the respiratory tract; Ingestion: May cause nausea, vomiting and diarrhea and Eyes: May cause irritation to the eyes.

Observation in an unlocked unisex bathroom indicated one container of an air neutralizer was on top of the towel dispenser. The container was labeled to keep out of reach of children. The MSDS described the following warnings: May cause eye and skin irritation, as well as respiratory irritation, may cause stomach distress and High vapor concentrations or excessive intentional inhalation may cause upper respiratory tract irritation, sleepiness, and/or dizziness, and eye irritation. Prolonged skin contact may cause mild redness and swelling. Contact with eyes may cause irritation, experienced as discomfort or pain, excessive blinking and tear production, with marked excess redness and swelling. Corneal injury may occur. This product could be absorbed through the skin.

The kitchenette area was an open area and nothing prevented the monitors or others from walking into the kitchenette area. The kitchenette area was very close to one tenant apartment and fairly close to another tenant apartment. When leaving the area the monitors met a tenant walking in the hallway and the tenant had something in his/her hand which appeared to be a piece of insulation or similar type material. The item was shown to staff who said it must have been from the construction area.

The ED was immediately notified and removed the chemicals and products of concern.

Observation of the dementia unit revealed concerns related to tenant safety and safe storage of chemicals.

- Regulatory Insufficiency: The buildings and grounds shall be well-maintained, clean, safe and sanitary. (IAC r. 481-69.35(1)(b))

M. Policies and Procedures

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Tenant #8 eloped from the Program on 2-9-14. Staff in the dementia unit was not aware Tenant #8 had exited the Program. According to the Program's policy Missing Resident Plan, the Program did not follow the policy in regards to the steps to take when a tenant was believed to be missing. An Incident Report was not completed. There was no documentation in the file to indicate the ED, Nurse, the tenant's responsible party or police was notified. The Program did not follow the Missing Resident Plan for what to do when the tenant's absence was not planned and the tenant returned to the building. The Program did not follow their policy for a Missing Resident Plan.

  Per the Program's Elopement Plan policy, if a tenant had left the building unescorted before staff intervened staff would immediately notify the Nurse and the Nurse would report the incident to the Department within 24 hours. The Nurse would reassess the tenant and determine if changes were needed in the tenant's service plan and if different interventions were needed.

The Nurse would orient staff on any new interventions for the tenant or corrective actions that were needed to reduce the risk of future elopements. The Program did not follow their Elopement Plan policy.

Per the Incident Reporting policy, whenever there was an incident involving a tenant, the staff present shall contact the person in charge, the RN and ED within 24 hours after the incident. The staff present would take any emergency actions necessary for the tenant and then complete an incident report as soon as possible. If the incident must be reported to the Department of Human Services, the RN would make the report as soon as possible and no later than 24 hours after the incident. If it was a reportable incident the RN would immediately begin an investigation. The RN would include in the tenant's file details of any incident involving the tenant and would document the follow up actions that were taken. The Program did not follow their Incident Reporting policy.

Policy review indicated the Program did not follow the policies established in regards to Missing Resident Plan, Elopement Plan and Incident Reporting.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2)